Mali

Contraceptive Logistics System

Review of Accomplishments and Lessons Learned (1988–1998)

Steve Kinzett Ramona Lunt







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FPLM

The Family Planning Logistics Management (FPLM) project is funded by the Office of Population of the Bureau for Global Programs, Field Support and Research of the U.S. Agency for International Development (USAID). The agency's Contraceptives and Logistics Management Division provides a centralized system for contraceptive procurement, maintains a database on commodity assistance, and supports a program for contraceptive logistics management.

Implemented by John Snow, Inc. (JSI) (contract no. CCP-C-00-95-00028-00), and subcontractors (The Futures Group International and the Program for Appropriate Technology in Health [PATH]), the FPLM project works to ensure the continuous supply of high-quality health and family planning products in developing countries. FPLM also provides technical management and analysis of two USAID databases, the contraceptive procurement and shipping database (NEWVERN); and the Population, Health, and Nutrition Projects Database (PPD).

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Abstract

This report details the efforts of the FPLM project to help the Government of Mali establish an effective contraceptive logistics system. The context of health sector reform and its associated changes in the country are described. This report describes an evaluation that was conducted to assess the status of the contraceptive logistics system and the effects of the changes associated with health sector reform on the system. Findings, lessons learned, and recommendations resulting from the study conclude the paper.







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Acronyms

AIDS acquired immune deficiency syndrome

AMPPF Association Malienne Pour la Planification Familiale (Mali Association of Family

Planning)

CBD community-based distribution

CFA communauté financière africaine (West African regional currency)

CPR contraceptive prevalence rate
CPT contraceptive procurement table
CYP couple-year of protection

DE Division Epidémiologie (Division of Epidemiology)

DLP Division Laboratoire Pharmacie (Division of Laboratory and Pharmacy)

DM Deutschemark (German currency)

DNSP Direction Nationale de la Santé Publique (National Directorate of Public Health)
DSFC Division de la Santé Familiale et Communautaire (Division of Family and Community

Health)

ECU European currency unit

FPLM Family Planning Logistics Management

GOM Government of Mali

GTZ Gesellschaft für Technische Zusammenarbeit (German Agency for Technical

Cooperation)

HIV human immunodeficiency virus

HMIS health management information system

HSR health sector reform

IEC information, education, and communication
IPPF International Planned Parenthood Federation

IUDintrauterine deviceJKKJama Ka Keneya

JSI John Snow, Incorporated

KfW Kreditenstalt für Wiederaufbau (German Development Bank)

LMIS logistics management information system

MCH maternal and child health

MSSPA Ministère de la Santé, de la Solidarité et des Personnes Agées (Ministry of Health,

Solidarity, and the Elderly)

NGO nongovernmental organization

PNLS Programme National de Lutte Contre le SIDA (National AIDS Prevention Program)

PPM Pharmacie Populaire du Mali (National Pharmacy of Mali)

PSPHR Projet Santé, Population et Hydraulique Rural (Project for Health, Population, and

Rural Water)

SDA schéma directeur d'approvisionnement (supply chain)

SDP service delivery point
STD sexually transmitted disease
TFGI The Futures Group International

UNAIDS Joint United Nations Programme on HIV/AIDS

UNFPA United Nations Population Fund UNICEF United Nations Children's Fund

USAID United States Agency for International Development

Preface

This report details the efforts of the Family Planning Logistics Management project, funded by the United States Agency for International Development, to help the Government of Mali establish an effective contraceptive logistics system. The original intent of this paper was to chart the status of the project. Shortly before the evaluation was to take place in August 1998, however, Mali started to implement a package of health sector reforms. As a result, the research team chosen to conduct the evaluation also turned its attention to the implications of health sector reform for future technical assistance.

This study involved the collection of qualitative data through key informant interviews with major stakeholders (appendix A lists contacts), a literature review, and a secondary analysis of existing data on the contraceptive logistics system and the reforms that the country was implementing.

The authors wish to acknowledge the contributions of Mrs. Aoua Diarra (then resident advisor for the Family Planning Logistics Management project in Mali), whose guidance during the assessment and intimate knowledge of the system were invaluable. In addition, we appreciate the cooperation of the staff at the USAID Mission in Bamako, who gave generously of their time and expertise. Thank you to the many people of both government and nongovernmental organizations contacted during this process, and all the people of Mali who were interviewed as part of the assessment, for sharing their perceptions and comments. We also wish to acknowledge the staff of FPLM/Washington, particularly Dana Gelfeld and Lisa Mueller, who contributed to and edited the final report for publication. Thanks also to the driver, Mr. Moussa Doumbia, who delivered us safely through many of the field visits in Sikasso, and especially within Bamako.

Executive Summary

The Family Planning Logistics Management project has provided technical assistance to the Government of Mali since 1988 to establish an effective contraceptive logistics system. In 1998, Mali began to implement a package of health sector reforms. This paper describes the results and lessons learned from a study conducted in August 1998 to assess the status of the contraceptive logistics system and the impact of the reforms on the system.

The primary changes in Mali that have had major effects on the contraceptive logistics system are the integration of the contraceptive and essential drug delivery systems and the move toward privatization. As one part of health sector reform, the Government of Mali combined the contraception and essential drug supply systems. As a result, the contraceptive logistics management information system was dismantled, and responsibility was shifted to a new agency—the National Pharmacy of Mali. In addition, the United States Agency for International Development awarded a contract to a private wholesaler, Jama Ka Keneya, to be the sole supplier of contraceptives in Mali. Therefore, the National Pharmacy, which had received contraceptives previously through a direct connection with The Futures Group International, was now required to purchase them from Jama Ka Keneya.

The experiences and study in Mali have highlighted several lessons learned:

- The Family Planning Logistics Management project should take a more proactive role in educating other stakeholders on the potential effects of integration on the contraceptive logistics management information system.
- The United States Agency for International Development should be more involved with the projects they fund so that a government's move toward integration will not conflict with successful projects already in place.
- A functional logistics management information system for family planning commodities needs to be retained during integration until a similar system is running for essential drugs.
- It is important to educate donors and other health stakeholders about the functions of a logistics management information system as opposed to a health management information system.
- Extensive donor coordination and information sharing among donors is necessary if health and development projects are to be complementary instead of conflicting.
- Political mapping of stakeholder interests at the central level will enable donors to design appropriate strategies for further technical assistance for contraceptive logistics.

Finally, several recommendations are put forward, including the following:

- The National Pharmacy of Mali should make personnel, transport, and budget resources available at the *arrondissement* and village levels so that supervisory activities can resume.
- Unless the present agreement for Jama Ka Keneya to supply contraceptives is changed, the National Pharmacy should order the required number of contraceptives to distribute to the regional and district levels.

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- The National Pharmacy of Mali should consider looking into the problem of packaging and selling
 the condoms donated by the Joint United Nations Programme on HIV/AIDS, as they are in danger
 of expiring before they can be distributed and used.
- The United States Agency for International Development should play a more proactive role in ensuring that projects developed under vertical health systems are not eroded by decisions made by other donors.
- Donors should be encouraged to hold regular coordination meetings, particularly for contraceptive commodities.
- The Family Planning Logistics Management project should consider developing a prototype for an integrated health system logistics management information system that will extend the already excellent logistics service in contraceptives to essential drugs.

Since the reforms were implemented and this study was completed, the Family Planning Logistics Management project has gained significant experience working in other countries undergoing health sector reform. The knowledge gained from the lessons learned in Mali has influenced the project's approach to working within the health sector reform context.

1. Study Protocol

The Family Planning Logistics Management (FPLM) project is a five-year project (1995–2000) funded by the United States Agency for International Development (USAID). Implemented by John Snow, Inc. (JSI), FPLM works to ensure the continuous supply of high-quality health and family planning products in developing countries. FPLM conducted a study in Mali to assess the status of the project in the country after several years of technical assistance and to examine the effects of health sector reform (HSR) on the contraceptive logistics system.

Study Objectives

The study objectives were four-fold:

- Document the joint FPLM-Government of Mali efforts in logistics, especially over the last five years.
- Evaluate the effect of integration on contraceptive logistics.
- Highlight the lessons learned during this time.
- Recommend strategies for the future.

Study Methods

The evaluation team consisted of the evaluation officer and a drug advisor from FPLM/Washington, and the resident logistics advisor from FPLM/Mali. Using a series of open-ended questions to gather information, the team made field visits to service delivery points (SDP), regional and district stores, and health facilities in Bamako, Mopti, Sikasso, and Tombouctou. The sites were chosen partly because of their accessibility and partly because they covered different areas of the country.

At the study sites, the investigators conducted key informant interviews with representatives from the government, nongovernmental organizations (NGO), private organizations, and international groups (e.g., donors, United Nations agencies, and the World Bank). Contact persons are listed in appendix A. The team members also reviewed relevant documents, reports, and records extensively.

2. Technical Assistance Strategy

FPLM has had a rich history of involvement with logistics management in Mali for more than a decade. In 1988, under FPLM I, FPLM staff started to make short-term visits to the country to provide technical assistance to the Division of Family and Community Health (DSFC) in the Ministry of Health, Solidarity, and the Elderly (MSSPA). At the time, Mali was setting up its logistics management information system (LMIS) for contraceptives under the aegis of the DSFC.

The project's mandate under FPLM II (1990–1995) was to help the Government of Mali ensure the availability of contraceptive commodities at maternal and child health (MCH)/family planning clinics and develop staff capacity to manage these contraceptive supplies. This was accomplished using short-term technical assistance from FPLM/Washington and by putting in place a resident advisor in 1994. Under FPLM III (1995–2000), the project continued to provide technical assistance in contraceptive logistics, mainly through the use of a resident logistics advisor.

Contraceptive Logistics before 1995

Mali had a highly effective contraceptive LMIS in place by 1993, five years after the start of FPLM assistance. At this point, the system needed a full-time resident advisor who could strengthen the system and train additional health staff in the logistics, forecasting, and management of contraceptive supplies. USAID thereupon granted a no-cost extension of the project to FPLM for the period, 1993–1997, at which time FPLM assigned a local resident advisor to work with the DSFC.

Unlike other countries with FPLM resident advisors, the FPLM office in Mali did not include additional support staff for the resident advisor. During her first two years, working virtually alone with little external technical assistance from FPLM/Washington, the resident advisor worked daily with the DSFC's National Training Team and Supply Department to provide technical assistance, training, and system design to all LMIS stakeholders, including those involved with HIV/AIDS prevention activities.

Among the technical assistance activities of the resident advisor were assisting with the annual preparation of USAID's contraceptive procurement tables (CPT); helping all family planning and HIV/AIDS programs with analyzing consumption and distribution data from quarterly logistics reports; and playing a central role in several FPLM evaluations of the entire LMIS, especially community-based distribution (CBD), transport, and storage.

The FPLM resident advisor also designed, developed, and produced curricula for LMIS training for personnel at all levels of the public health system and for all concerned NGOs. She trained a number of DSFC regional teams in the heavily populated southern half of the country. Each regional team was made up of the divisional chief, regional midwife, and regional information, education, and communication (IEC) advisor. This training covered family planning logistics and such related areas as reproductive health technology and IEC strategies.¹

Upon completion of their training, the DSFC staff transferred their knowledge to other colleagues (usually a chief physician, midwife, and IEC staff member) in each district, who then trained additional

The resident advisor also took part in FPLM training and evaluation activities conducted in Senegal, Haiti, Burkina Faso, and Côte d'Ivoire, providing "south-to-south" technical assistance to similar FPLM projects in other Francophone countries.

staff down to the *arrondissement* level. By the end of 1995, all staff at all levels of the public health system had been trained to use the LMIS that FPLM had helped to put in place.

The contraceptive distribution system in Mali was essentially a push system, where higher-level facilities determined the needs of lower-level facilities. Nurse-midwives, CBD workers, and other staff delivering family planning services recorded inventories of contraceptives. These data were relayed to *arrondissement* staff, who calculated the number and type of contraceptives to be ordered each quarter. The information was passed on to the district, then to the region, and then to the central level so accurate calculations could be made for all contraceptive supply needs across regions. The same system was used by the other organizations dispensing contraceptives, such as NGOs.

The resulting composite picture allowed the resident advisor, the DSFC, the NGOs, and The Futures Group International (TFGI)—a contraceptive social marketing group—to compile the annual CPTs that USAID requires before ordering and delivering contraceptives to a country. It also meant that calculations could be made of couple-years of protection (CYP) and the contraceptive prevalence rate (CPR). The extensive training of staff later allowed FPLM to create a pull system for contraceptives, where health facilities determine their own contraceptive needs, to replace the push system in place prior to 1993.

Effects of Reform

In 1995, with the support of donor agencies and the urging of the World Bank, the Government of Mali (GOM) decided to combine the contraceptive logistics system with the essential drug supply system; integration was completed by the end of 1997. The view was that contraceptive availability was only a small function of the health system, and that integration would cut costs and avoid duplication of efforts. With the same intention as integration, the World Bank and the donor agencies also established a common basket to accept donor funds and distribute them across all public health programs, including family planning.

As a result of this decision, the DSFC's contraceptive LMIS was dismantled. Overall responsibility for contraceptive procurement and delivery shifted to the Project for Health, Population, and Rural Water (PSPHR) within the National Pharmacy of Mali (PPM), where the essential drug supply system was based.²

This radical change in contraceptive logistics meant that supplies were to travel through the same pipeline as essential drugs and, like the drugs, were to be delivered to the customer by the pharmacist rather than the family planning nurse. The Government of Mali accordingly developed a pricing structure (see appendix B), whereas prior to this change, contraceptives were free.

USAID was to supply most of the contraceptives directly to the government. (Previously, USAID supplied TFGI, which had been supplying the government with contraceptives.) Intrauterine devices (IUD) and Norplant® would continue to remain outside the system because the United Nations Population Fund (UNFPA) supplied these contraceptives to the DSFC under a separate agreement.³

In addition, the government would no longer receive dispensed to user data and had to rely only on "issues data," the number of contraceptives issued to the lower levels of the system, to determine contraceptive need. These issues data were compiled by the regions from the PPM warehouses and

Contraceptives on the essential drugs list are the combined pill (Norgestrel 0.3mg + ethinyl estradiol 0.03mg); the progestative pill (Norgestrel 0.075mg); Depo-Provera[®] injectable (medroxyprogesterone acetate 150mg); spermicide vaginal foaming tablet (nonoxynol 9); latex condoms; intrauterine device (Cu-T 380a), and the subdermal implant Norplant (levonorgestrel 136mg).

UNFPA may only work with government agencies, and cannot work through private organizations.

storerooms at various levels of the system, but were not indicative of the actual use of contraception at the SDPs where clients were served (appendix C shows an example of a stock record).

Move to Privatization

In 1996, in the spirit of privatization encouraged by HSR, USAID (the major supplier of contraceptives), issued a solicitation calling for private and public wholesalers to bid on becoming the sole supplier of the contraceptives that USAID donated to the Government of Mali. PPM refused to take part in the bid process, holding that its mandate to supply essential drugs to government facilities now extended to include contraceptives as well.

The winner of the USAID contract was a private wholesaler, Jama Ka Keneya (JKK). To accommodate the previous contract for supplies with the TFGI, the bid specified that the new supplier was to clear all USAID-donated contraceptives through customs and repackage the products for sale and distribution. JKK was to sell the contraceptives to PPM at a price fixed by the Government of Mali.

PPM would distribute the contraceptives through its essential drug distribution network, from which they would be sold to health facilities. The health facilities, in turn, would sell the contraceptive commodities to clients seeking them. Appendix B displays the pricing structure at the various levels of the distribution network.

However, because PPM purchases contraceptives from JKK reluctantly, there is a shortage of contraceptives at the regional level, and many district health officers go directly to JKK for these supplies, rather than waiting to obtain them through the PPM regional wholesalers.

3. Results of the Assessment

Using qualitative methods (interviewing key informants, consulting documents, and making extensive notes), a picture of the contraceptive system with the various stakeholders was built. Below are the results of these investigations.

Contraceptive Distribution

The distribution system for essential drugs and contraceptives is fairly complex. Figure 1 is a flow chart identifying the organizations and levels in the system and the distribution network infrastructure, as described to the investigators.

The Mali public health system operates at five levels: central, regional, district, *arrondissement*, and SDP. Today, the public sector distribution network for both contraceptives and drugs starts with the PPM and its central warehouse. From this point, the supplies go to PPM's regional warehouses, which send them on to distribution depots (*dépôts repartiteurs*) located in the larger regional and district health facilities.

The distribution depots supply the drugs and contraceptives to district health facilities and sales depots (*dépôts de vente*) in the community. These outlets sell the commodities to clients by prescription. The distribution depots also supply the village CBD agents in one of several ways: from supervisors on their periodic visits, from medical assistants at community or district health facilities, or the agents go to a depot themselves. On occasion, certain NGOs and the regional branches of AMPPF may also get supplies at PPM's district distribution depots, when necessary (see dotted lines on figure 1). These entities of the distribution network implement the drug supply chain (*schéma directeur d'approvisionnement* or SDA).

Stakeholders

There are many stakeholders in the Mali health system who play different roles for the family planning program, including five broad groups: international donor agencies, government agencies, NGOs, private organizations, and the World Bank.

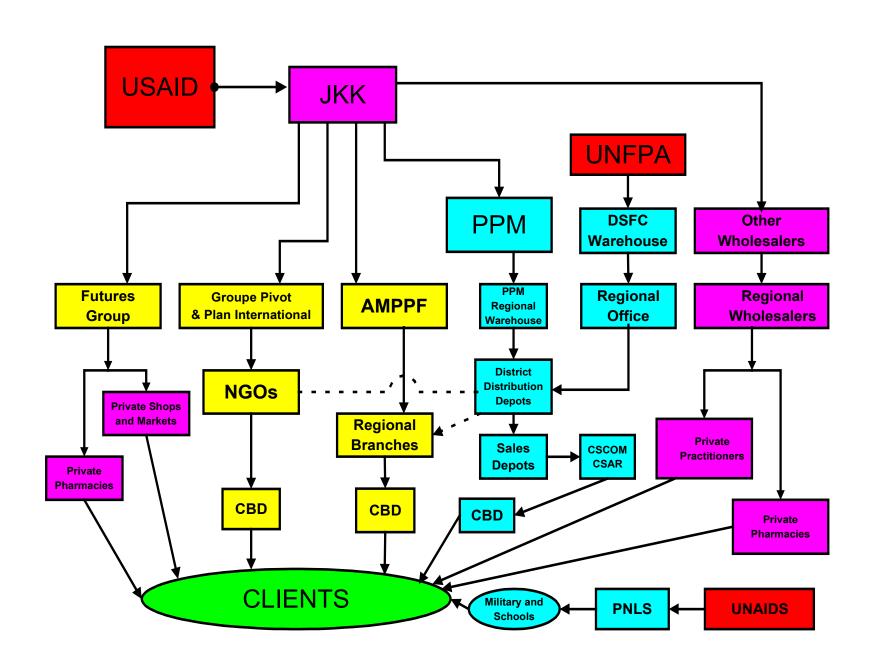
International Donors

U.S. Agency for International Development (USAID)

USAID has been rendering assistance to health and population programs in Mali for more than 20 years. The agency has expended U.S.\$41.5 million in nine segments to the health sector, some of which has been for JSI/FPLM assistance in the logistics management of contraceptives, and over U.S.\$8 million has been for procurement of contraceptives. The investment made in the technical assistance of family planning and reproductive health programs over the last ten years means that USAID is one of the largest stakeholders. It contributes to the "basket of funds" for health coordinated by the Project for Health, Population and Rural Water (see PSPHR), but also has many projects outside this basket; the technical assistance provided by FPLM is one. Other projects carried out by USAID alone include MCH, equipment purchase, research, and other health activities.

Figure 1.Contraceptive Distribution in Mali after Health Sector Reform





United Nations Population Fund (UNFPA)

UNFPA began working in Mali in 1974 and quickly established coordination with USAID and other donors. The new five-year program began in April 1998 and is fairly large—U.S.\$6.5 million for reproductive health. Before USAID started supplying contraceptives, the main donor was UNFPA. At present, UNFPA supplies IUDs and Norplant directly to the DSFC through an outstanding agreement, although there have been no deliveries since the integration of contraceptives and essential drugs because there are adequate supplies in country. They also have some projects that concentrate on women's and children's health. The donation of contraceptives is still an option, but UNFPA reports that this will be done in coordination with USAID to complement services rather than compete, and only at the request of the Government of Mali.

International Planned Parenthood Federation (IPPF)

IPPF no longer supplies contraceptives to Mali. The IPPF local affiliate, Mali Association of Family Planning (AMPPF), now obtains its supplies through JKK (see JKK). However, IPPF is included as a stakeholder here because it may supply contraceptives again in the future.

United Nations Children's Fund (UNICEF)

Although UNICEF does not donate contraceptives, it does donate funds for essential drugs, and therefore is a stakeholder in the system. In fact, it seems that UNICEF was partly responsible for encouraging the integration process and, in turn, determining that the contraceptive information system was unnecessary.

Other donor stakeholders

In addition to the above, other donors in the health system of Mali include the Dutch government, the Belgian Cooperation working in Kita District, and the German International Development Agency (GTZ) working in two districts near Mopti. Coopération Française has stopped funding health projects and switched to "salt iodization," but it continues to support rural water programs. The European Union has committed 10.22 million ECU, and the German Development Bank (KfW) committed DM 13 million into a basket for health that is supplemented by a World Bank loan of U.S.\$29 million coordinated by PSPHR (see paragraph about PSPHR).

Government of Mali

The Ministry of Health, Solidarity, and the Elderly (MSSPA)

The MSSPA has a budget of well over 400 million CFA francs and comprises the usual divisions in such a ministry. The organizational chart of the MSSPA is complex (see appendix D), but only a few of the divisions are relevant to the supply and management of contraceptives, as described below.

The National Directorate of Public Health (DNSP)

The DNSP is the head of the central technical directorates and is responsible for a number of divisions that look after reproductive health and family planning services.

The Division of Family and Community Health (DSFC)

The DSFC is responsible for keeping the community services of family planning running, even though they have had no control over the supply of family planning commodities since integration began. Prior to 1997, the DSFC had been instrumental in coordinating the contraceptive information system with the FPLM resident advisor. When the political decision was made to integrate contraceptives into the essential drugs program, the DSFC effectively lost control over the supply of family planning products, and the estimation of the quantities needed for the country passed to the Division of Laboratory and Pharmacy (DLP). It also meant that the DSFC warehouses and stores were no longer used to store contraceptives other than IUDs and Norplant . The DSFC is still responsible for supplying IUDs and Norplant because these products are donated by UNFPA, which can only work with the government (MSSPA), whereas the contraceptives donated by USAID are in the hands of a private organization (see JKK).

The Division of Laboratory and Pharmacy (DLP)

With the decision to integrate, the DLP suddenly became responsible for ensuring that contraceptives and essential drugs were available in the health system. The majority of contraceptives were placed on the essential drug list that the DLP is responsible for maintaining. The exceptions were IUDs and Norplant , for the reasons given above. The contraceptives were to be treated like any other essential drug, but now the DLP had the task of telling USAID (or any other donor) how much of which contraceptive products to supply to Mali. Thus, the DLP has to rely heavily on FPLM technical assistance, as well as other stakeholders involved in contraceptive distribution, to provide reliable and realistic estimates of quantities needed.

The Division of Epidemiology (DE)

The DE is also a stakeholder because it compiles the statistics for the health system. These include such statistics such as the number of people using particular methods of contraception, number of sexually transmitted diseases (STD), and HIV/AIDS. These figures are collected on extensive forms that have a number of sections, depending on the level in the system. The DE claims that it has a 92 percent reporting rate, which would enable its statistics to be used in the estimation of contraceptives after these have been validated (see appendix E).

The National AIDS Prevention Program (PNLS)

Also within the MSSPA is the National AIDS Prevention Program (PNLS), responsible for HIV/AIDS control in Mali. However, there are no special STD/HIV clinics in the country, and the division is largely concerned with IEC. Over 1.6 million condoms were provided by the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 1996; many of these remain undistributed because, according to the public health system, condoms have to be sold. Therefore, special groups such as the military and students are the only recipients of these free condoms. The remaining supplies are kept in a PNLS central warehouse, where they are being depleted at a very slow rate and are due to expire by 2001.

The Project for Health, Population, and Rural Water (PSPHR)

This is actually a coordinating project within MSSPA to advise on and coordinate donor and loan money in a basket of funds for health programs. The PSPHR has health as its primary interest, not family planning, and this was reflected in the organization's decision to support the integration of contraceptives into the essential drug supply. The PSPHR is a fairly powerful wing of MSSPA; it coordinates all donor

and loan funds for health by holding an annual planning meeting to apportion funds within the overall five-year plan period.

The National Pharmacy of Mali (PPM)

One of the largest stakeholders in terms of the provision and distribution of both essential drugs and contraceptives is the PPM. This wing of the MSSPA is basically a pharmaceutical wholesaler whose responsibility is to purchase drugs on the open market and feed them through the system using its regional-level facilities. The PPM's mission is to supply the health system with the commodities it needs, but it acts as a private company—in other words, it should make a profit, which is then shared with the MSSPA. The PPM is currently forced to buy contraceptive products from a private wholesaler (JKK—see JKK) to supply its regional facilities, because JKK won a contract to serve as the sole supplier of USAID-donated contraceptives. The PPM refused to take part in the bid for the contract, because the PPM regarded it as its mission to supply essential drugs, including contraceptives, for the government. In other words, it saw no reason to bid on a project to provide services it considered to be already under its mandate. As a result, the PPM has been reluctant to order contraceptives from JKK, in turn resulting in shortages of contraceptives at the regional level. Many district health officers have subsequently decided to go directly to JKK for supplies rather than working through the PPM regional wholesalers.

Nongovernmental Organizations (NGO)

Mali Association of Family Planning (AMPPF)

During this evaluation, the staff of AMPPF, the local IPPF affiliate, was on enforced vacation and could not be consulted directly. However, AMPPF is another stakeholder that operates in different areas of Mali and works with the public system in providing support and supervision of CBD agents in villages.

Groupe Pivot

Groupe Pivot is a coordinating umbrella organization for 147 international and national NGOs in Mali, of which 22 are working in health. Funded by USAID, Groupe Pivot was formed in 1992 to bring the NGOs together in one organization and to prevent fragmentation. In addition to promoting the use of contraceptives, Groupe Pivot has projects in maternal and child health, vaccinations, and other health-related topics. It probably has the best LMIS for family planning in the country and reported no stockouts at all in the previous year because of excellent supervision and supply mechanisms. Many of the NGOs under this coordination operate a CBD network for condoms, pills, and vaginal foaming tablets. These efforts are reported through the information system that the FPLM resident advisor put in place. Group Pivot's work feeds directly into the general health effort for the country.

The Population Council

The Population Council does for the public sector what Groupe Pivot does for the NGO sector in terms of CBD of contraceptives. In Mali, the Population Council carried out a pilot project for CBD that began in 1990. The Council showed that the CPR in 54 villages rose from 1 to 11 percent overall from 1990 to 1993. In some villages it rose to as high as 31 percent, and this led to an implementation project to expand CBD to 3,000 villages by providing technical assistance funded by USAID (U.S.\$8 million). In the year since integration of contraceptives and essential drugs occurred, there have been some fairly large stockout problems. Indeed, in Sikasso, the CPR dropped from 8 percent in 1996 to 5 percent in 1997 within the villages where the Population Council's CBD agents were working. This is directly attributable

to the lack of supply and supervision that changed after integration. An example of the Population Council's CBD reporting form is shown in appendix F.

Plan International

Plan International is another international NGO that funds and supports smaller national and local NGOs. In four districts in Mali it provides total development assistance to certain villages and communities, including support for agriculture, social development, water, family planning, and MCH. Contraceptives come from the public system, although Plan International would like to keep an emergency stock in Bamako. In addition to these activities, Plan International has a special project with USAID funding for STD/AIDS prevention. This project started in January 1995 and totals some U.S.\$7 million over five years to work in 1,900 villages using over 100 trained organizers (*animateurs*) and NGO coordinators. The *animateurs* supply and supervise CBD agents in these villages.

Private Organizations

Jama Ka Keneya (JKK)

There are a number of national wholesalers for pharmaceuticals in Mali; Jama Ka Keneya (JKK) is one of these. What sets it apart from the others is that it won the bid to become the sole supplier for contraceptives donated by USAID to the country in July 1997. Prior to this, contraceptives were supplied to the TFGI social marketing activity located within PPM. It was in the spirit of privatization that JKK won the contract to be the wholesaler for contraceptives in Mali. Operating from a series of large shops in Bamako, JKK receives contraceptives from USAID, repackages them for social marketing, and then sells them to other whole-salers and directly to district and regional health departments, NGOs, private pharmacies, and others. Recent problems have included a shortage of packaging for the social marketing products and stockouts of Depo-Provera® (Confiance).

Other Pharmaceutical Wholesalers

A number of other wholesalers compete for business in the pharmaceuticals industry (Laborex, Africalab, etc.) However, they, too, must buy from JKK. The prices of the products are fixed.

The Futures Group International (TFGI)

TFGI has a bilateral contract with USAID/Washington to provide social marketing of contraceptives for Mali (this was **not** under the global SOMARC III project). Prior to integration of the contraceptives and essential drugs, TFGI was the recipient of all USAID contraceptives based within PPM. Now TFGI has its own premises where it socially markets condoms in Mali through a team of about 20 promoters (six have been trained by FPLM). A small number of pills and injectables are sold to private physicians. However, TFGI is directly responsible for technical assistance to JKK to help the company repackage USAID products for social marketing throughout the system. In addition, TFGI handles all IEC and marketing of the brand names Protector (for condoms), Pilplan (for pills), and Confiance (for injectables). TFGI has a good information system for sales, including statistics for packaging materials. This is computerized and will be passed on to JKK as a continuation of the technical assistance in this area. TFGI has been a key stakeholder in Mali because it was mandated to provide technical assistance in logistics, information systems, social marketing, IEC, and training. Some of this was accomplished with FPLM support through the resident advisor.

World Bank

As in many other countries, the World Bank has been instrumental in encouraging Mali to reform its health system, including family planning, to focus on cost recovery. The decision to integrate the contraceptive supply with the essential drug supply was supported by the Bank. The World Bank loan to the GOM for health-related activities amounted to U.S.\$29 million, of which U.S.\$19 million was in the form of special drawing rights. Although the government insists that the World Bank has minor influence on health policy, the Bank obviously influences MSSPA activities.

Forecasting

Dispensed to user data are now available only in the private and NGO sectors. The reports generated each month and quarter by a plethora of NGOs, some of which are quite small, are accurate and timely and are coordinated by Groupe Pivot.

Sales figures by the TFGI promoters are also indicators of contraceptive use. Although these numbers are not dispensed to user figures, they can be used reliably for projecting the demand in the private sector (appendix G). However, if the TFGI's sales agents are selling to the same people who supply the NGO CBD agents, or if parts of the public system get their supplies from these traders, there is a risk of overcounting.

In the public sector, projections of contraceptive need are now limited to data on issues of contraceptives from JKK and PPM wholesalers. The service statistics being collected by the DE are a potential source of additional government information. Again, they are not dispensed to user data and would have to be validated before use

Supervision

Under integration, government health workers no longer have the means to make supervisory visits to CBD agents and SDPs. Thus, although the CBD agents still faithfully record data on who is receiving contraceptives, and how many and what type are going out, the information goes nowhere, so the nurses at the SDPs have stopped collecting this information. Thus, integration has resulted in a breakdown of the contraceptive information system and resupply mechanisms. NGOs, however, are still able to supervise and, therefore, resupply their CBD agents through routine visits.

4. General Findings

In 1995, with the commitment to integration, Mali's excellent, well-run contraceptive information system was swept aside in the interest of an integrated health delivery system. The decision to integrate was made at the highest government levels, without any understanding of the implications for forecasts of contraceptive needs. Despite the current lack of a contraceptive information system in the public health system, however, family planning supplies are still coming through the pipeline and arriving at SDPs, largely because of special efforts by regional and district staff.

Health versus Family Planning

The question remains—Could the government's decision to integrate the flow of contraceptives and drug supplies have been handled differently, or even prevented, so that the contraceptive information system could have survived even in the face of reform? The short answer is—no. Developing countries almost always attach more political power, interest, and importance to the delivery of general health care than to the delivery of family planning services. If anyone had raised the probability that contraceptive forecasting would be impeded, the decision makers probably would have held that the "issues data" from JKK's warehouse are sufficient for calculating future needs.

The lack of proper forecasting data emphasizes the difference between essential drugs as curative health measures and contraceptives as preventive health ones. The products serve different purposes; therefore, they should be treated differently.

Availability and choice are cases in point: In countries such as Mali, where essential drugs are always in short supply, patients wait for a needed drug, accept a substitute, or go without. Contraceptive prevalence, on the other hand, depends on the consistent availability and variety of contraceptive supplies. Not only are family planning clients poorly served if their chosen method of contraception is available one month and not the next, but contraceptive prevalence is affected when the client chooses instead to discontinue use of contraception because the supply is unreliable. This seems to have been overlooked in Mali.

Supervisory Systems

The close coordination between the NGOs and MSSPA workers at the district level and below has kept NGOs and MSSPA from duplicating efforts at the lower levels. Thus, although no government CBD agents are working under the aegis of the Population Council at these levels, the NGOs are still able to supervise, and therefore resupply, their own CBD agents during routine supervisory visits.

Donor Coordination

In the groundswell of support for integration, projects developed under vertical systems, often costing hundreds of thousands of dollars, have been cast aside. As a result, half of the effort that FPLM put into logistics management of contraceptives in Mali is essentially wasted, and hundreds of specially trained public health workers no longer provide the information required to ensure an adequate supply and delivery of contraceptive commodities. Fortunately, the country is still reaping results on the NGO side, because the NGOs working in family planning continue to use the logistics system.

Central-Level Conflicts

The major problem found by the evaluation team is the flow of contraceptives from the central level. The PPM is apparently reluctant to order contraceptives from JKK, possibly to force the issue of USAID reconsidering its decision to have an open competitive bid to handle all contraceptives in the country.

It is virtually impossible to account for these central-level conflicts because they are bound up in politics, territory, and a desire for control. However, there should have been much greater consultation between the Government of Mali and USAID when the procedures for supplying contraceptives under the new system were being developed.

5. Lessons Learned

Integration, one of the components of health sector reform for developing countries, continues to be supported by many donors and the World Bank. In view of this situation, the Mali experience provides a number of lessons for preserving elements of a logistics system that provided exactly the right kind of data needed to manage the supply and distribution of contraceptives. Some of the lessons learned can also be applied by FPLM to other countries receiving technical assistance in logistics.

- 1. **FPLM should take a more proactive role in educating other stakeholders on the potential effects of integration on the contraceptive LMIS.** If FPLM had coordinated its efforts with other nongovernment stakeholders in Mali, it might have been possible to supplant the current reliance on issues data with alternative ways for gathering information on contraceptive distribution. In this way, LMIS expertise at the regional level and below could have been used by decision makers integrating the two systems.
- 2. USAID should be more involved with the projects it funds so that a government's move toward integration will not conflict with successful projects already in place. During integration, USAID should have worked to make other donors aware of the possible demise of the successful efforts made under vertical programs. It is very difficult to coordinate donor efforts, but the PSPHR is mandated to do just that. However, the PSPHR was willing to sacrifice the contraceptive logistics information system in the face of overwhelming support for establishing integrated systems.
- 3. A working LMIS in family planning commodities needs to be retained during integration until a similar system is running for essential drugs. If one system is to be integrated into the other, the profile of family planning services and its associated logistics and information systems must be raised. In Mali, where this was not done, the family planning program may well be lost within the general health system. At the least, the reporting system for family planning should be retained until a successor system has been established. An even better tactic might be to adapt the reporting system already developed for contraceptives to the essential drugs system.
- 4. It is important to educate donors and other health stakeholders about the functions of an LMIS as opposed to a health management information system (HMIS). An HMIS does not serve the same function as a logistics management information system. HMISs tend to collect data on incidence of diseases and numbers of patients rather than quantities of drugs/commodities used. The donors pushing HSR did not understand the functions of the contraceptive LMIS and thought that an integrated HMIS would serve the same purpose. An LMIS that captures the quantities of commodities distributed to clients will provide the data required to make accurate and timely forecasts for procurement. The accuracy of these forecasts is critical in a full-supply family planning program.
- 5. Extensive donor coordination and information sharing among donors is necessary if health and development projects are to be complementary instead of conflicting. As the earlier discussion detailed, it is entirely possible for funds or projects from one donor in an integrated health system to directly affect projects in vertical systems that are in progress or have been completed.

Mali: Review and Lessons Learned

6. Political mapping of stakeholder interests at the central level will enable donors to design appropriate strategies for further technical assistance for contraceptive logistics. It is, therefore, important to recognize, understand, and try to deal with central-level concerns—for example, the tension between the PPM, TFGI, and JKK. The vested interests at central levels, where the attitude and behavior of staff can affect even decentralized systems, can hamper implementation of the best-designed logistics and information system.

6. Recommendations

The recommendations that follow are divided into three categories—those addressed to the Government of Mali, to USAID, and to FPLM—because they involve different concerns at different levels.

Government of Mali

- 1. *Integration*. Integration of health sector activities in Mali has effectively lost one-half of the country information for consumption of contraceptives. Policymakers did not understand the critical importance of an operations-oriented government family planning information system.
 - *Recommendation*: There should be no complacency about the integration process in countries implementing HSR. In Mali, as elsewhere, contingency plans must be developed to cope with integration of health delivery systems.
- 2. Supervision for the integrated system. To identify the quantity of contraceptives and drugs being consumed, Mali's new integrated system for health delivery needs an adequate mechanism that will enhance supervision and collect information on both contraceptive and drug use from the peripheral levels of the system. The medical assistants at the *arrondissement* and village health facilities may have the time and capability to conduct supervision, but lack the necessary resources to do so.
 - *Recommendation*: The PPM should make personnel, transport, and budget resources available at the *arrondissement* and village levels so that supervisory activities can resume.
- 3. *Central-level resupply of contraceptives*. Conscientious district and regional workers should not have to go to Bamako for contraceptive supplies when these products could be available from the PPM regional stores.
 - *Recommendation*: Unless the present agreement for JKK to supply contraceptives is changed, the PPM should order the required number of contraceptives to distribute to the regional and district levels.
- 4. *Condoms for STD/HIV prevention.* The UNAIDS-donated condoms held by the PNLS, which were intended to be distributed free of charge, are in danger of expiring before use because the Government of Mali refuses to distribute them for free in the public sector because of the established pricing structure.
 - *Recommendation*: The PPM should consider looking into the problem of packaging and selling these condoms. If this investigation could cause more problems than it would solve, it may be wiser to encourage the PNLS to think of special projects and target groups to whom they could give the condoms.

USAID

- 5. Consulting with government. Misunderstandings and recurrent breakdowns in communication between USAID and the government (MSSPA) have occurred since about 1995, often to the detriment of the health care delivery systems.
 - Recommendation: USAID and MSSPA need to build bridges so that they can ascertain what each expects from the other in terms of family planning commodity supply, and then go on to coordinate donor efforts in health and family planning in a mutually agreeable manner. Continuing involvement by TFGI in the social marketing of contraceptives in the private sector also needs to be clarified, as does the role of government in its own social marketing effort. In this way, duplication of effort will be avoided, and services can reach the widest possible range of clients.
- 6. Donor coordination. Apparently, USAID has not been as involved as some of the other donors in the overall health program in Mali. Whereas some have been actively engaged in discussing HSR and have been contemplating the use of basket funding for certain activities, USAID has continued to implement its own plans with the government.

Recommendation: USAID should play a more proactive role in ensuring that projects developed under vertical health systems are not eroded by decisions made by other donors in the absence of information on potential resource wastage under the integrated system. Regular donor meetings are one way to coordinate efforts. If such meetings are not feasible, USAID should send short briefing documents to other donors on important projects.

FPLM

- 7. *Immediate need for injectable contraceptives.* JKK no longer has supplies of injectables at the central level; and as elsewhere in Africa, contraceptives such as these are becoming increasingly popular in Mali. At the time of this study, the situation was compounded by the fact that there is a general shortage of Depo-Provera in the United States because of manufacturing delays. It is also difficult to obtain packaging materials locally for such socially marketed products as Confiance.
 - *Recommendation:* Logistics advisors should assess the situation immediately and, if necessary, place an emergency order with USAID for a shipment of the injectable contraceptive. The logistics advisor should also recommend delivery of the unpackaged product to the regions and launch an investigation of the situation. An alternative solution is to ask UNFPA to place an emergency order for Depo-Provera in Europe, where there are fewer manufacturing problems.
- 8. Forecasting contraceptive need. The NGO contraceptive information base is still intact and can be used to project NGO contraceptive need. This situation, however, does not hold true for the public sector. Until the conflict at the central level can be resolved, FPLM can help the government forecast contraceptive needs.
 - *Recommendation*: FPLM logistics advisors, with help from the various agencies supplying information, should compile data on stock issues from JKK and PPM to the regions and districts with data from the DE's reporting system. This information can help the government prepare the CPTs that USAID requires for delivery of contraceptives.
- 9. *Donor coordination*. FPLM is increasing its role as the coordinator for donors supplying contraceptives. Donor coordination is especially important in countries where, as in Mali, more than one donor supplies contraceptives. For example, in Tanzania and Bangladesh, the donors come

together routinely at the initiative of FPLM to decide future contraceptive shipments for the countries.

Recommendation: FPLM should encourage the donors to hold regular coordination meetings, particularly for contraceptive commodities. Ideally, these meetings should be convened by the MSSPA.

10. Integrated logistics management information system. If donors had come to realize the importance of an LMIS for the effective supply of contraceptives, the progress made to date might not have been cast aside so readily. Integration processes are now a fact of life in many parts of the developing world, and they will figure significantly in future collaborative work between governments and donors.

Recommendation: FPLM should consider developing a prototype for an integrated health system LMIS that will extend the already excellent logistics service in contraceptives to essential drugs. With expertise in this area as a result of work in Nepal and the Philippines, FPLM should consider setting up a task force on integration with representation from logistics advisors, training advisors, and drug supply management staff.

11. Closer guidance of country activities by FPLM. Despite comprehensive reports detailing the impending integration of essential drugs and contraceptives in Mali, there was no decisive reaction to this situation from FPLM/Washington. On two visits to Mali, Washington staff could have helped reduce the negative impact integration had on the contraceptive logistics information system if they had they fully recognized the potential negative consequences.

Recommendation: Resident advisors need more substantive and more frequent contact with FPLM/Washington, including feedback on work plans and field activities.

Appendix A.List of Contacts

GOVERNMENT

Division Laboratoire Pharmacie (DLP)

M. Traoré, Amara, Pharmacist

Dr. Maiga, Minkaïla, Division Chief

Division de la Santé Familiale Communautaire (DSFC)

Dr. (Mme) Sangaré, Madina, Chief

Dr. Diakité, Sira Mama, CDD, ARI

Dr. Touré, Attaher, Physician

Mme. Diallo, Mariame, Midwife

Projet Santé, Population et Hydraulique Rural (PSPHR)

M. Simpara, Cheick Hamed Tidiane, Project Coordinator

Dr. Sanogo, Brehima, Technical Coordinator

Programme National de Lutte Contre le SIDA (PNLS)

Dr. Maiga, Yehia, Program Coordinator

Direction Nationale de la Santé Publique (DNSP)

Dr. Kané, Mamadou, National Director

Pharmacie Populaire du Mali (PPM)

M. Diko, Mohamed, President Director

Office of Secretary General, MSSPA

Dr. Maiga, Zakaria, Secretary-General

Dr. Maiga, Moussa, Technical Advisor on Public Health

Division Epidémiologie

Dr. Berthé, Adama, Chief

Mopti Region

Dr. Oyé, Aghama, Regional Pharmacist

M. Guindo, Boubacar, CBD Advisor

Dr. Tangara, Pharmacist, PPM Regional Stores

Dépôt Repartiteur de Cercle – Mopti District

M. Diakité, Hamadoun, Head, District Health

Centre de Santé d'Arrondissement Revitalisé (CSAR), Fatoma, Mopti Region

M. Diko, Nouhoum, Center Chief

Village Manako - Mopti Region

M. Touré, Tiemoko, CBD Agent

Mme. Yattara, Fanta, CBD Agent

Action Sociale - Mopti Region

M. Coulibaly, Issaka, Regional Director

Sikasso Region

Dr. Traoré, Amadou, Population Council CBD Coordinator

Division de la Santé, Regional Hospital

Dr. Kokaïna, Sidiki, Chef

Mme. Diamouterie, Marie Lawrence, Midwife

Centre de Santé d'Arrondissement Revitalisé (CSAR) - Klela District

M. Koné, François, Medical Assistant

Mme. Diarra, Alimata, CBD Agent

Loutana Village (7kms from Klela)

M. Mohammed, CBD Agent

PPM Regional Stores - Sikasso

M. Koureissi, Mahmoud, Medical Assistant (Regional Pharmacist on leave)

District Health Center - Sikasso Region

Dr. Bagayoko, Dougoufana, Chief Physician

M. Sissoko, Mahamadi, Administrator

NONGOVERNMENTAL ORGANIZATIONS

Population Council

Dr. Doumbia, Seydou, Program Coordinator

Groupe Pivot

M. Maiga, Modibo, Coordinator

Plan International

Dr. Kanté, Mamadou, Head of the health program

PRIVATE

Futures Group

M. René Rovira, Chief of Party

Jama Ka Keneya (Groupement d'Intérêt Economique - Santé pour Tous)

Dr. Maiga, Agassoumane, Chargé des Approvisionnements

DONORS/INTERNATIONAL

USAID

Ms. Ursula Nadolny, PHN

Ms. Andrea Yates

Mr. Salif Coulibaly, Health Results Package Manager

Mr. Bamoussa Coulibaly, Assistant Results Package Manager for Health

Mr. Madiou Yattara

Mr. Ousmane Haidara

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Community Health and Population Services (CHPS) project, JSI bilateral project

Tim Rosché, Chief of Party Kriss Barker, IEC Specialist

UNFPA

Dr. Cissoko, Mariam, Health Consultant M. Traoré, Mantala, Program Head

WHO

Dr. Cissé, Sarmoye, Public Health Advisor

Appendix B.
Contraceptive Pricing List

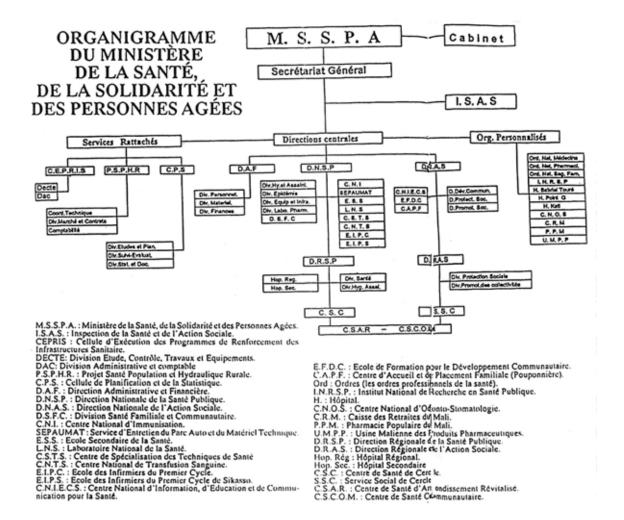
3. PRIX DE VENTE DES CONTRACEPTIFS PAR NIVEAU

Produit	Niveau	Prix de vente
Duofem (Pilplan)	JKK ⇒ PPM	30 F CFA
	PPM ⇒ DRC	50 F CFA
	DRC ⇒ DV	60 F CFA
	DV ⇒ Client	100 F CFA
Ovrette	JKK ⇔ PPM	30 F CFA
	PPM ⇒ DRC	50 F CFA
	DRC ⇒ DV	60 F CFA
	DV ⇒ Client	100 F CFA
Depoprovera (Confiance)	JKK ⇒ PPM	100 F CFA
	PPM ⇒ DRC	150 F CFA
	DRC ⇒ DV	200 F CFA
	DV ⇒ Client	300 F CFA
Conceptrol	JKK ⇒ PPM	30 F CFA
	PPM ⇒ DRC	45 F CFA
	DRC ⇒ DV	55 F CFA
	DV ⇒ Client	80 F CFA
Condom (Protector)	JKK ⇒ PPM	10 F CFA
	PPM ⇔ DRC	15 F CFA
	DRC ⇒ DV	25 F CFA
	DV ⇒ Client	50 F CFA
DIU (Tcu 380a)	PPM ⇔ DRC	1000 F CFA
	DRC ⇔ DV	1500 F CFA
	DV ⇒ Client	2500 F CFA
Implant (Norplant)	PPM ⇔ DRC	1000 F CFA
	DRC ⇒ DV	1200 F CFA
	DV ⇒ Client	1500 F CFA

Appendix C.
Stock-Level Issues Data Form

			Dépôt de .	CHE DE STO				
	ODE	D. C.	ı. ———			Dosage	Forme	Unité de vente
x d'achat			Unités		Stock Maximur	m		Unité
x de vente			Unités		Stock Minimur			Unito
DATE	Nº BON	ORIGINE	DATE PEREMPTION	DESTINATAIRE	Е	NTREES	SORTIES	STOCK

Appendix D. MSSPA Organizational Chart



Appendix E.

Division of Epidemiology Report Forms

Ministère de la santé, de la solidarité et des personnes agées Secrétariat général Direction nationale de la santé publique

REPUBLIQUE DU MALI

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Cercle:		_ Type de ce	ntre: CS	Com _	_ c	SA
	,	■ Population	aire:			habitants (
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	Fonction /	Source(s) de		Nombre d	e jours d'a	bsence
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					-	
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Réunions du Conseil de Gestion ou de l'organe faisant fonction

Date et Numéro du Compte Rendu/P-V	Les 2 principales Décisions prises
,	
Nombre de réunions pendant le Trimestre:	,

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Code	Affection	Définition
A00	Choléra	Malade de 5 ans ou plus présentant un épisode aiguee de diarrhée aqueuse avec ou sans vomissements dans une région ou une épidémie de choléra confirmée est en train de sévir
A09	Diarrhée présumée infectieuse en dehors du choléra	Malade présentant des selles molles > 3 fois/ jour avec ou sans signe(s) de déshydratation: fontanelle déprimée; yeux enfoncés, pleurs sans larmes, bouche sèche, soif, pli cutané persistant
B05.9	Rougeole	Malade présentant une fièvre supérieure à 38°5, associée à une éruption maculo-papuleuse généralisée, précédée par une conjonctivite et accompagnée d'une rhinopharyngite et de toux
A35	Tétanos	a) néo natal: Bébé de moins de 30 jours, ayant eu une naissance normale, ayant tété normalement, qui ne peut plus téter et a de la raideur et des convulsions. b) de l'adulte: Contractures et spasmes douloureux des muscles de la machoire, puis de la nuque et du tronc
A80.9	Poliomyélite	Tout nouveau cas de paralysie flasque d'un membre au moins, d'apparition récente chez un enfant de moins de 15 ans et qui ne s'explique pas par une cause évidente (traumatisme)
G039	Méningite cérébrospinale	Malade présentant une fièvre supérieure à 38°5 associée à une raideur de la nuque, qu'il ait ou non des vomissements
J15.9	Toux < 15 jours, I.R.A. basses: Pneumonie, bronchopneumonie	 a) Enfant: présentant une fièvre avec ou sans toux et une respiration trop rapide pour son âge: > 60/min avant 2 mois; > 50/min avant 1 an; et > 40/min avant 5 ans. b) Adulte: présentant une fièvre élevée et de la toux et/ ou géne respiratoire, et une respiration non sifflante.
706 700-	I.R.A. hautes (Rhinopharyngite, rhinite, angine, otite, trachéite)	Malade avec ou sans fiévre, dont la respiration n'est pas trop rapide, mais qui présente un ou plusieurs symptomes respiratoires: mal de gorge, otalgie, rhinorrhée, otorrhée, toux
A16.9	Toux > 15 jours (tuberculose)	Toux supérieure à 15 jours, quel que soit la cause, qui persiste aprés un traitement antibactérien non spécifique correct
B54	Fièvre (paludisme présumé)	Malade présentant 4 signes majeurs: fièvre supérieure à 38°5 en rectal (38° axillaire); céphalées; frissons répétés ; et sueurs
A71.9	Trachome	Malade présentant des follicules derrière la paupière supérieure
B65.0	Hématurie: (bilharziose urinaire)	Malade présentant des urines sanglantes, surtout en fin de miction, qui ne sont pas accompagnées de fièvre ni d'oedèmes
N34.2	Uréthrite aigue	Malade présentant des brûlures à la miction associées à un écoulement uréthral purulent entre et/ou aprés les mictions
N76.6	Ulcération génitale	Plaie sur les organes génitaux interne (femme) ou externe
A65	Syphilis endémique	Ulcération(s) arrondie(s) saignant facilement et/ou recouverte(s) d'un enduit grisatre, sur la face interne des lèvres ou des joues
E43	Malnutrition proteino-calorique	Enfant présentant un poids inférieur à la ligne inférieure de la courbe de croissance et un ou plusieurs des signes suivants: dépigmentation des cheveux, plaque d'hyperpigmentation de la peau, oedèmes, anémie, ballonnement abdominal et gros foie
026.9	Troubles liés à la grossesse	Fausses couches; avortements; hémorragies génitales, hyper- tension artérielle et/ou oedemes chez une femme enceinte
090:9	Troubles liés à l'accouchement et au post partum	Dystocie, infection génitale et/ou hémorragie pendant et/ou aprés l'accouchement (jusqu'à 40 jours aprés l'accouchement)
K00- K14	Traumatismes, plaies, brûlures	Toute lésion superficielle et/ou profonde, consécutive à un traumatisme, qu'il soit physique, chimique ou éléctrique
H00-59	Affections oculaires	Toute afféction oculaire, en dehors du trachome (cf A71.9)
B24	Affections bouche et dents	Toute les affèctions de la bouche ou des dents (gingivostomatite herpétique, candidose, abcés dentaire, etc)
	Autres	Toute affèction non classable dans une catégorie ci dessus

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Prise en charge de la	Mois 1	Mois 2	Mois 3	TRIMESTRE	
N Suspects pour lesquels on a e	nvoyé des lames				
N Malades en traitement au déb	ut de la période				a:
N Malades pris en charge (ouver	ture d'une fiche)				b:
Dont: Tuberculose Pulmonaire	TPM BK +				
	BK -				
Tuberculose Extra-Pu	monaire -TEP				
Rechûtes	,				Charles Carles
Transferts à partir d'un a	utre CS/Hopital				
N Traitements arrêtés (fermetu	e d'une fiches)				C:
Dont: Guérison confirmée pa	r le laboratoire				
. Traitement achevé					CHANGE TO SHOW AND
Echec de traitement					
Transfert d'une autre for	mation sanitaire				
Interruption du traitemen	nt par le malade				324
N Malades en traitement à la f	n de la période			7. 1.	d:

F	Prise en charge de la lèpre	Mois 1	Mois 2	Mois 3	TRIMESTRE
N Sus	pects pour lesquels on a envoyé des lames				100
N Mal	ades en traitement au début de la période				a: It become
Dont:	Lèpre Pauci-Bacillaire (PB)				
	Lèpre Multi-Bacillaire (MB)				
N Mala	ades pris en charge (ouverture d'une fiche)				b:
Dont:	NC Lèpre Pauci ou Multibacillaire (PB/MB)				Marie Marie
	Mutilation chez nouveau cas PB- MB				
	Autres (AC, transfert) PB reçu				
	Autres (AC, transfert) MB reçu				
N Trai	itements arrêtés (fermeture de la fiche)				c:
Dont:	Guérison (PB ou MB)				- 3.5 - 5.4 - 3.4 - 3.4
	Décés (PB ou MB)				1 1 1 2 A
	Transfert vers une autre formation (PB)	7		7 1	and the second
	Transfert vers une autre formation (MB)				- B. B. B.
	Abandon (PB ou MB)				
N Mala	ades en traitement à la fin de la période				d:
Dont:	Lèpre Pauci-Bacillaire (PB)				
	Lèpre Multi-Bacillaire (MB)				

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Traitement Communautaire malades de l'Onchocercose	Mois 1	Mois 2	Mois 3	Total trim.
Nombre de villages ayant reçu de l'Ivermectine				
Nombre d'individus ayant reçu de l'Ivermectine				

Activités promotionnelles	Mois 1	Mois 2	Mois 3	Total trim.
Nombre de séances d'IEC dans la formation sanitaire				
Nombre de séances IEC hors de la formation sanitaire				
Nombre de séances de démonstration nutritionnelle				
Nombre de séances d'animation hygiène/assainissement				West of the

Section 3. Gestion Des ressources

Ge	estion finan médicam	S02900	Mois 1	Mois 2	Mois 3	TRIMESTRE
Montant e	en Banque en	début de période				All the Salar Salar
Montant en Caisse en début de période						
		Total				a:
Recettes	Tarification					
	Tranfert ca	isse médicaments				
	Autres, à	a.				
préciser b.		b.				
		Total				b:
Dépenses	Salaires et	charges sociales				A Specifical
	Fonction-	a.				1 700 77
	nement	b.				
		c.				7.7
		d.				SHAMES.
		Total				c:
Montant	en banque e	en fin de période			A 100 - 50 - 54	
Montant	en caisse e	n fin de période			1.00	
		Total			-	d:

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Kappon trimestriei Caconic.	3/1. uc	All	. Illunesuc		a

Gestion	Financière	Médicaments	Mois 1	Mois 2	Mois 3	TRIMESTRE
Valeur mé	dicaments en	début de période				
Montant e	n Banque en	début de période				
Montant e	n Caisse en	début de période				
		Total				a:
Recettes	Vente de m	nédicaments				
	Autres, à	a.				
	préciser	b.				
		Total				b:
Dépenses	Paiement	des médicaments				
		dans le compte isse de tarification				
	Autres, à	a.				
	préciser	b.				
		c.				
		d.				
		Total				C:
Valeur stoc	k médicament	ts en fin de période				
Montant e	en banque e	n fin de période				1000
Montant e	en caisse e	n fin de période				1 1
		Total				d:

Cha	ine de froid		Mois 1	Mois 2	Mois 3	TRIMESTRE
Température	La plus haute	8 h				
	(< + 8°?)	14 h	,			
	La plus basse	8 h				
	(> + 1° ?)	14 h				
Nombre jours	d'arrêt pour	panne				entrefreiteil Tot
Nature de	la/des par	nne(s)				
Réparations	faites (Oui ou	Non)				
Logistique	e ()	Mois 1	Mois 2	Mois 3	TRIMESTRE
Etat de	son Début pe	ériode				
fonctionnen	nent Fin de pe	ériode				1 2 200
Nombre jours	d'arrêt pour	panne				
Nature de	la/des par	nne(s)				
Réparations 1	faites (Oui ou	Non)				

Rapport trimestriel	CSCom/CSA. de	/	An 1	Trimestre	Page 14
Sect	tion 4.	and the second second	grand and	o de la proposición de la constanta de la cons	emilys disa.

PROBLEMES IDENTIFIES ET SOUMIS A DISCUSSION LORS DES SUPERVISIONS

Problèmes	. Date discussion avec l'équipe de supervision	Solutions envisagées	Responsable de l'exécution

Rapport trimestriel CSCom/CSA.	de	An Trim	estre Page 15
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Section 5.

RAPPORT DE MORBIDITE ET DE MORTALITE

	建筑大学的基础 统	190.3	TRIMESTRE							TO	TAL	
Code	Affection	6		mols				4 ans	150	na +		STATE OF
9 1449	是是第2位mxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	17.0	M	13	M	F	M	F	M	F	M	F
A00	Choléra	Cas									May.	
		D-C									850	2000
A09	Diarrhée présumée infectieuse	Cas									-014	
	en dehors du choléra	D-C								- 7		
B05.9	Rougeole	Cas									147153	2925
		D-C										1636
A35	Tétanos	Cas			_	_	_	_	_	_	1000	X POR
		D-C				_					Selection of the select	
A80.9	Poliomyélite	Cas			_			_	_		1000	1000
		D-C					_	_				
G039	Méningite cérébrospinale	Cas		_			_		_		- C100	14550
		D-C										
J15.9	Toux <15 jours, I.R.A. basses:	Cas					_	_	_		- Property	3 1005
	pneumonie, bronchopneumonie	D-C							_			
J00-	I.R.A. hautes (Rhinopharyngite,	Cas				_	_	_				33,22
J06	rhinite, angine, otite, trachéite)	D-C				_	_	_	_		He Committee	6,000
A16.9	Toux > 15 jours (tuberculose)	Cas		_			_	_			1200	
		D-C						_				2,5000
B54	Fièvre (paludisme présumé)	Cas					_	_				
A71.0	Y	D-C				_	_	_	_			E 500.3
A71.9 B65.0	Trachome	Cas		_		_		_				70000
N34.2	Hématurie (bilharziose urinaire)	Cas										BATTLES BATTLES
N76.6	Uréthrite aigue Ulcération génitale	Cas			_		_		-	_		
A65	Syphilis endémique	Cas		-		_	_		\vdash	_		17 13 13 Zak
E43	Malnutrition proteino-calorique	Cas	_	-		_	_		-			2000
L45	Maniatrition proteino-calonque	D-C	-	$\overline{}$	-	_				_		
026.9	Troubles liés à la grossesse	Cas	_	-	_		_			-	1000000	
020.5	Troubles lies a la grossesse	D-C	$\overline{}$	-	-							Caraca Co
290.9	Troubles liés à l'accouchement	Cas		_	$\overline{}$					$\overline{}$	3000000	2 5 x 30
	et au post partum	D-C	_	_	$\overline{}$		_			$\overline{}$	53000	
368.8	Traumatismes, plaies, brùlures	Cas								$\overline{}$	-	
	praise, praise, praise	D-C		$\overline{}$	$\overline{}$						CORNER.	ottlere
100-59	Affections oculaires	Cas		_	$\overline{}$						1.654	
(00-	Affections de la bouche et des	Cas	_	-	-		-		-		ALEXANDER OF	
(14	dents	D-C	-+	_			_		-	\dashv		
$\overline{}$	Autres	Cas			$\overline{}$				$\overline{}$	-	200000	000000
		D-C	_	:		_	$\overline{}$			-		

	Rapport trimestriel CSCom/CSA. de	An Trimestre Page	16
	Observations (ESCom)		٦
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Rapport envoyé le/1199	Signature:	Rapport reçu le/1199.	•
Rapport envoyé le//199	Signature:	Kapport reçu le//199.	
Rapport envoyé le//199	Observations (E.S.S.C.)	Kapport reçu le//199.	 7
	Observations (E.S.S.C.)	Kapport reçu le//199.	7
	Observations (E.S.S.C.)		-
	Observations (E.S.S.C.)		

Rapport trimestriel CSCom/CSA. de _____An ___. Trimestre ___. Page 7

September 1	Affection		0.11	mois	1-4	MOI		arıs	15ar	16 ÷	TOTAL		
Code	Affection		M	F	M	F	M	F	M	F	М	F	
A00	Choléra	Cas				a collections						19953	
		D-C									00000		
A09	Diarrhée présumée infectieuse	Cas										55	
	en dehors du choléra	D-C										NO.	
B05.9	Rougeole	Cas											
		D-C										3	
A35	Tétanos	Cas									,	學學	
		D-C											
A80.9	Poliomyélite	Cas										TO THE	
		D-C											
G039	Méningite cérébrospinale	Cas									ATTEMPT	引起则	
		D-C									EG. LANS	理器	
J15.9	Toux < 15 jours, I.R.A. basses:	Cas									31/28/3	All the	
	pneumonie, bronchopneumonie	D-C									-	制能。	
J00-	I.R.A. hautes (Rhinopharyngite,	Cas											
J06	rhinite, angine, otite, trachéite)	D-C				1							
A16.9	Toux > 15 jours (tuberculose)	Cas									95000	3 (182)	
		D-C											
B54	Fièvre (paludisme présumé)	Cas										THE REAL PROPERTY.	
		D-C											
A71.9	Trachome	Cas									Production in		
B65.0	Hématurie (bilharziose urinaire)	Cas							1			567	
N34.2	Uréthrite aigue	Cas										開放	
N76.6	Ulcération génitale	Cas									24	Shart	
A65	Syphilis endémique	Cas									Section .	Marie 1	
E43	Malnutrition proteino-calorique	Cas										19/05	
		D-C										1900	
026.9	Troubles liés à la grossesse	Cas											
		D-C										7900	
090.9	Troubles liés à l'accouchement	Cas									1	STATE OF THE PARTY	
	et au post partum	D-C										alexu.	
R68.8	Traumatismes, plajes, brùlures	Cas										用族	
		D-C										- Approx	
H00-59	Affections oculaires	Cas											
К00-	Affections de la bouche et des	Cas									Albert .	319%	
K14	dents	D-C										The same	
	Autres	Cas									57		
		D-C									10000	12	

		A AMERICAN	A processor con to							biographic and the second	A STORY OF THE REAL PROPERTY.	-
			THE !	200		MO			STEEL ST		то	TAL
Code	Affection	200		mols	114			4 ens		- Comments	1	
	分类的		M	F	W	F	W	G	IVE	F	M	2
A00	Choléra	Cas	_	_			_	<u> </u>	-	_		
	·	D-C			_			├	├	_	300	
A09	Diarrhée présumée infectieuse	Cas						├	ـ			1000
	en dehors du choléra	D-C			_			┞	<u> </u>		A Const	
B05.9	Rougeole	Cas					_	┞	_			3000
		D-C		_	_			├	-	_		
A35	Tétanos	Cas		_	_			_	_		la de	Sec
		D-C			_			_	_			413
A80.9	Poliomyélite	Cas		_				_	_		73/2513	15000
		D-C		_					_			18.50
G039	Méningite cérébrospinale	Cas		_				_	_		##3E	DE SON
		D-C						_	_			
J15.9	Toux <15 jours, I.R.A. basses:	Cas		_					_		3000	1760
	pneumonie, bronchopneumonie	D-C						_	_			3885
J00-	I.R.A. hautes (Rhinopharyngite,	Cas					_	_	_			-500
J06	rhinite, angine, otite, trachéite)	D-C						_			956	
A16.9	Toux > 15 jours (tuberculose)	Cas						_				7.30
		D-C									HIS.	-0.75
B54	Fièvre (paludisme présumé)	Cas									600	7 8
		D-C										1000
A71.9	Trachome	Cas						_				1888
B65.0	Hématurie (bilharziose urinaire)	Cas									WA 183	
N34.2	Uréthrite aigue	Cas							1			1418
N76.6	Ulcération génitale	Cas									17.650	被影
A65	Syphilis endémique	Cas										
E43	Malnutrition proteino-calorique	Cas									• 30	1770
		D-C										1200
026.9	Troubles liés à la grossesse	Cas									- 20	
		D-C										
090.9	Troubles liés à l'accouchement	Cas										The second
	et au post partum	D-C										
R68.8	Traumatismes, plaies, brùlures	Cas									15	
		D-C										18.50
H00-59	Affections oculaires	Cas										
коо-	Affections de la bouche et des	Cas										-
K14	dents	D-C										18,62
	Autres	Cas				\neg						(100 April 100 A
		D-C										97.6

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		1000	10.50	24/		MO					TOTAL		
Code	Affection	5	0-11 M	mois F		F			15an M		М	F-F-	
	Choléra	0	FILV ISS	100.00	T V	140	LVI	201.00	SULB	23,500	33.44	23.10	
A00	Cholera	Cas D-C	-	-	-	-	-	-		_	1942	30000	
***	Disable antonnée infectious	-	-	-	-	-	-	-			1000		
A09	Diarrhée présumée infectieuse en dehors du choléra	Cas D-C	-	-	-	-	-	-			(SIC-US)	3000 3000	
BOE 0		-	_	-	-	-	-	-					
B05.9	Rougeole	Cas D-C	_	-	-	_	-	-	\vdash		000000	31333	
A 2 E	Titones	-	-	-	-	_	-	-	\vdash			10000	
A35	Tétanos	Cas D-C	_	-	-	-	-	-					
A80.9	Poliomyélite	Cas	_	-	-	_	-		\vdash		25,451		
A80.9	Pollomyelite	D-C	_	-	-	_	-	_	\vdash		72,728	Trains.	
G039	Méningite cérébrospinale	Cas	_	-	-	_	_	_			20		
0039	Werlingite Cerebrospinale	D-C	_	-	-	\vdash	_	_	\vdash			199	
J15.9	Toux <15 jours, I.R.A. basses:	Cas	_	-	-	-	_	_			0.000		
315.5	pneumonie, bronchopneumonie	D-C		-		_	_	_	\vdash		120,00	3-6,8575	
J00-	I.R.A. hautes (Rhinopharyngite,	Cas	_	_	_	_	\vdash	_	\vdash				
J06	rhinite, angine, otite, trachéite)	D-C	_	_		_	_	_				Air o	
A16.9	Toux > 15 jours (tuberculose)	Cas	_	_			_		\vdash				
A10.5	Toux > To jours (tuberculose)	D-C	_	_				_	\vdash		10 CH	180	
B54	Fièvre (paludisme présumé)	Cas	_	-		_		\vdash	\vdash		155	eloze.	
554	Pievie (palduisine presume)	D-C	_	-		_	_	_					
A71.9	Trachome	Cas		-	_		_		\vdash				
B65.0	Hématurie (bilharziose urinaire)	Cas	_			_	_		\vdash		130000	0.100	
N34.2	Uréthrite aigue	Cas	_	_		_	_		\vdash			74	
N76.6	Ulcération génitale	Cas	_	-		_	_					83.5	
A65	Syphilis endémique	Cas							\Box		Great Control		
E43	Malnutrition proteino-calorique	Cas							\Box		THE	1000	
		D-C							\Box			34	
026.9	Troubles liés à la grossesse	Cas										Secret	
		D-C											
090.9	Troubles liés à l'accouchement	Cas									37.5		
	et au post partum	D-C											
R68.8	Traumatismes, plaies, brùlures	Cas									01/9/20	Elect.	
		D-C									92		
H00-59	Affections oculaires	Cas									100746	1268	
коо-	Affections de la bouche et des	Cas											
K14	dents	D-C									(Line)		
	Autres	Cas											
		D-C											

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PAQUET MINIMUM D'ACTIVITES: POPULATION DE L'AIRE (1)

7 25 12	- Color			AC	TIVITES	S CURA	ATIVES	3				
Période Age	Mois 1			Mois 2			Mois 3			TRIMESTRE		
	0-4 ans	5 ans et +	Total	0-4 ans	5 ans et +	Total	0-4 ens	5 ans et +	Total	0-4 ans	5 ans et +	Total
N nouveaux épisodes NC												
N total de consultations									1			
N référés →												
N évacués →												

2 60	SANTE REPRO	DUCTIVE	-Femmes	4	
Suivi gross	esse / accouchement / Suite de couches	Mois 1	Mois 2	Mois 3	TRIMESTRE
N Séances	Cons Pré Natales en Centre Fixe				
	C.P.N. en Stratégie Avancée				
N nouvelles in	scriptions aux Prénatales (= NC)				
N Total cons	sultations Prénatales (= NC+ AC)				
N Accouche	ments Assistés (dans le Centre)				
	A domicile ou en route				
N nouvelle	s consultations post-natales				
N référées -	>				
N évacuées -	•				58.5 / L.T.
N décés mate	rnels				
	Planification Familiale	Mois 1	Mois 2	Mois 3	Total Trim.
N séances	Cons. P. Familiale en Centre Fixe				
	C.P.F. en Stratégie Avancée				
N nouvelles	inscriptions en P. Familiale (NC)				
N Total Con	sultations P. Familiale (NC+AC)				
Nombre de	Plaquettes de pillules distribuées				
	Dispositifs Intra Utérins insérés				
	Condoms distribués				
	Spermicides distribués				
	Injectables administrés				
N femmes réf	érées pour Planification Familiale				

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PAQUET MINIMUM D'ACTIVITES: POPULATION DE L'AIRE (2)

	Suivi des enfants	100	Mois 1	Mois 2	Mois 3	TRIMESTRE
60 GE			WIOIS 1	WOOS Z	WOOD D	1000
N séances		ns en Centre Fixe				E. Comment
		ns en S. Avancée				
N nouvelles	inscriptions					
		12-23 mois				
		Total				
N Total de d	consultations	0 - 11 mois				
		12-23 mois				
		Total				
Total de consultations 1		strées (0-23 mois)				
The second secon			Mois 1	Mois 2	Mois 3	TRIMESTRE
Enfant Polio 0		0 - 15 jours		7 1		100
	Polio 0 B.C.G.	0 - 11 mois				
		12-23 mois				
	V.A.R.	0 - 11 mois				
	DTCP1	12-23 mois				
		0 - 11 mois				
		12-23 mois				
	DTCP2	0 - 11 mois				Constant of the Constant of th
	Programme Elargi de V Int Polio 0 B.C.G. V.A.R. DTCP1 DTCP2 DTCP3 Fiévre jaune	12-23 mois				
	DTCP3	0 - 11 mois				
		12-23 mois				A.C. Control
	Fiévre jaune	0 - 11 mois				
	,	12-23 mois				
Femmes	enceintes	VAT1				0.04450
. Gilliles		VAT2				
		VAT Rappel				
		VAT1				
	encentes	VAT2				
		VAT Rappel				akeRoells

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Section 2 b

PAQUET MINIMUM D'ACTIVITES: POPULATION HORS AIRE (1)

				AC	TIVITES	S CURA	TIVES	5			ve j	
Période Age	Mois 1			Mois 2			Mois 3			TRIMESTRE		
	0-4 ans	5 ans et +	Total	0-4 ans	5 ans et +	Total	0-4 ans	5 ans et +	Total	0-4 ans	5 ans et +	Total
N nouveaux épisodes NC												
N total de consultations												
N référés →												
N évacués →						1						

"美统统"。	SANTE REPR	RODUCTIVE	-Femmes	*蒙慰与法	验 建气
Suivi grosse	esse / accouchement / Suite de couches	Mois 1	Mois 2	Mois 3	TRIMESTRE
N Séances	Cons Pré Natales en Centre Fixe			X///////	<i>X////////////////////////////////////</i>
	C.P.N. en Stratégie Avancée			X///////	X////////
N nouvelles i	nscriptions aux Prénatales (NC)				
N Total Cons	sultations Prénatales (NC+ AC)				
N Accouchen	nents assistés (dans le Centre)				
	à domicile ou en chemin				
N nouvelles	consultations post-natales				
N référées →					
N évacuées →					
N décés mater	rnels				
P	lanification Familiale	Mois 1	Mois 2	Mois 3	TRIMESTRE
N séances	Cons P. Familiale en Centre Fixe				X////////
	C.P.F. en Stratégie Avancée			<i>X////////</i>	<u> </u>
N nouvelles in	nscriptions en P. Familiale (NC)				
N Total cons	ultations P. Familiale (NC+AC)				
Nombre de	Plaquettes Pillules distribuées				
	Dispositif Intra Utérin insérés				
	Condoms distribués				
	Spermicides distribués				
	Injectables administrés				
N femmes réfé	rées pour Planification familiale				

Rannort	trimestrial	CSCom/CSA.	do	An	. Trimestre	. Page 6
Rappent	umesurei	Cacom/CaA.	ac		. ITHIICSUC	r age o

PAQUET MINIMUM D'ACTIVITES: POPULATION HORS AIRE (2)

- 10 miles	A STATE OF THE STA	SANTE REPR	ODUCTIVE-	Enfants		在一个大学
100	Suivi des enfant	s sains	Mois 1	Mois 2	Mois 3	TRIMESTRE
N séances	suivi enfants sa	ins en Centre Fixe				X////////
	suivi enfants sa	ins en S. Avancée		X///////		X////////
N nouvelles	inscriptions	0 - 11 mois		1		
		12-23 mois				
		Total				
N Total de	consultations	0 - 11 mois				* * * * * * * * * * * * * * * * * * *
		12-23 mois				All Car
		Total				Post Control
N gellules V	/itamine A admin	istrées (0-23 mois)				1000
Prog	ramme Elargi de '	Vaccination	Mois 1	Mois 2	Mois 3	TRIMESTRE
Enfant Polio 0		0 - 15 jours				
	Polio 0 B.C.G. V.A.R.	0 - 11 mois				
	1	12-23 mois				
	V.A.R.	0 - 11 mois				
		12-23 mois				
	DTCP1	0 - 11 mois				
		12-23 mois				
	DTCP2	0 - 11 mois				
		12-23 mois				1
	DTCP3	0 - 11 mols				
		12-23 mois				9
	Fiévre jaune	0 - 11 mois				
		12-23 mois				
Femmes	enceintes	VAT1				are to the second
		VAT2				194 34 199
	nmes enceintes	VAT Rappel				of Alexander
	non enceintes	VAT1				
		VAT2				Mark Mark
		VAT Rappel				SHE BUS

Appendix F. Population Council's CBD Report Forms

Popu	ulation Council/Pr	ojet D	BC Mali							
1	FIC	:HF	DE	SACT	1//1	TES M	IFNSI	JELLES	<u>`</u>	
Région de		ercle (de	A	rrond	issement		village_		
Mois de _	c				Date o	de la supe	rvision:		_	
Nom & Pre	enom du Superv	iseur						/_		
Nom & Pré	enoms animateu	rs sup	ervisés:	ď					1	1 / /
		o our		٩						7 7
				+						
		AU	NIVE	AU ANI	MATI	EUR.				
I. GESTIC	ON DES PROD	UITS	CONT							
		\vdash		ANIMATI				ANIMATE	UCE	6
		4	Condom	Spermi	cide	Pilule	Condom	Spermicio	lc	Pilule
Stock au déb		\perp								
Quantité reç		\perp								
Quantité ver	ndue									
Somme perç	ue									
Stock en fin	de mois									
II. ACTIV	ITES IEC :			ANIMA	TEHR			ANIMATI	BIC	F
							1/45		1	
	ivités menées		VAD	Counselin	ng	Causeries	VAD	Counseling	-	Causeries
Thèmes			\vdash		\rightarrow		-		_	
	l'espacement de nais		\vdash		\rightarrow		-		<u> </u>	
Méthodes de	grossesses rapproch	bes	$\overline{}$		\rightarrow		-		\vdash	
	rr sation des méthodes c	a DE	-		-				\vdash	
		e PF	-		\rightarrow		-		_	
	nires de la pilule nellement transmissib	Jane	\vdash		\rightarrow				-	
Prévention de		ies	$\overline{}$		\rightarrow		++		_	
Infertilité	s intections		-		\rightarrow		-		\vdash	
	écoces et tardives		$\overline{}$		-				\vdash	
Sida: commen					$\overline{}$				_	
Autres thèmes					\rightarrow				_	
III. <u>SUIV</u> I										
Nouveaux ac										
				Hommes				Femme	25	
Condom										
Spermicide										
Pilule										
Recrutées : in										
	Total									
Anciens acc	epteurs									
Condom										
Spermicide Pilule										
Recrutées: in	iectables								_	
	Total									

Population Council/Projet DBC Mali

IV. CLIENTS AYANT FAIT 3 APPROVISIONNEMENTS OU PLUS DANS L'ANNÉE :

Pilule Injectable TOTAL	Femmes	- -			
V. REFERE	ENCES:				
	Nombre de clients	(e) réferés (e)			
	Réfer	é (e) pour effets é (e) pour autres é (e) pour autres	secondaires ave s problèmes de s s raisons	c la méthode un anté // //	
Stock au déb Quantité reçu Quantité sort Stock en fin d	ie : ie : de mois: ervées au cours de la	supervision :	Condom	Spermicide	Pilule Injectable
	Nombre Ca	useries : Counseling			
Obser	vations :				
VII. GESTIC	ON DES FINANCE	S:			-
0		Condoms	Spermicides	Pilules	Injectables
Quantité vend			-	-	
Somme totale			-		
	e à l'animateur le par le superviseur		-		
Somme perçu	e par le superviseur			1	

Cachet et Signature

Appendix G. TFGI's Sales Figures

CONF 97-98

Confiance sales analysis

22,185

	_											
1997	January	February	March	April	May	June	July	August	September	October	November	December
Est. sales					3,500	3,500	3,500	4,500	4,500	6,000	6,000	6,000
Actual sales					2,468	4,632	10,464	9,353	8,256	14,000	11,024	0
Quarterly sales			0)		7,100			28,073			25,024
Monthly averag	je 7,5	25										
Annual Total	60,1	97										
Annual CYP	15,0	49										

YTD analysis	AMV	Sales	Est sales	Variation	Sales	Est. sales	Var. to date	Last year	Variation	Last year	Variation
	Prev. year	Curr. month	Curr. month	%	to date	to date	sales v proj	month	%	to date	%
		0	6,000	-100.00%	60,197	37,500	60.53%				

Estimated sales 97: 37,500

1998	January	February	March	April	May		June	July	August	September	October	November	December
Estimated sales	7,500	7,500	7,500	9,375		9,375	9,375	11,000	11,000	11,000	12,000	12,000	12,000
Actual sales	5,023	6,657	14,689	13,943		7,268	11,089	30,069					
Quarterly sales			26,369				32,300						
Monthly average	12,677												
Annual Total	88,738	1											

YTD analysis AMV Var. to date Last year Sales Est sales Variation Sales Est. sales Variation Last year Variation Prev. year Curr. month Curr. month % to date to date sales v proj month to date 7,525 30,069 11,000 173.35% 88,738 44.00% 17,564 405.23% 61,625 10,464 187.36%

Estimated sales 98: 119,625

Annual CYP

PIL 97- 98

Source:	Pilplan s	sales analys	sis										
The]	1997	January	February	March	April	May	June	July	August	September	October	November	December
Futures	Estimated sales	45,000	45,000	45,000	47,000	47,000	47,000	49,500	49,500	49,500	49,500	49,500	49,500
ıres	Actual sales	40,478	65,030	24,311	30,194	17,210	34,227	73,764	54,735	50,780	50,765	52,271	21,469
Group	Quarterly sales			129,819			81,631			179,279			124,505
dnc	Monthly average	42,936											
Inte	Annual Total	515,234											
rna	Annual CYP	34,349											
International	VTD analysis	AMV	Sales	Est sales	Variation	Sales	Est. sales	Var. to date	Lastuane	Variation	Lastuass	Variation	1
al (YTD analysis			Curr. month		to date	to date	sales v proj			Last year to date	%	
(TFGI)		31,838		49,500	-56.63%	515,234	573,000		20,275		382,057	34.86%	
Annual Report	Estimated sales 97:	573,000]										
ort.	1998	January	February			May			August	September		November	December
Mali	Estimated sales	50,000		50,000	55,000	55,000				65,000	70,000	70,000	70,000
_	Actual sales	76,460	34,320	84,800	52,716	30,220	50,440	100,265					
998	Quarterly sales		1	195,580			133,376	J		100,265			0
	Monthly average Annual Total	61,317	-										
	Annual CYP	429,221 28,615	{										
	Annual CTP	20,013	J										
	YTD analysis	AMV	Sales	Est sales	Variation	Sales	Est. sales	Var. to date	Last year	Variation	Last year	Variation	1
		Prev. year	Curr. month	Curr. month	%	to date	to date	sales v proj		%	to date	%	
		42,936	100,265	65,000	54.25%	429,221	380,000	12.95%	73,764	35.93%	285,214	50.49%	

Estimated sales 98: 720,000

PROT 97-98

Protector sales analysis

1997 revised Est.sales Actual sales Quarterly sales Monthly average Annual Total Annual CYP

January	February	March	April	May	June	July	August	September	October	November	December
300,00	0 300,000	300,000	325,000	325,000	325,000	350,000	350,000	350,000	375,000	375,000	375,000
219,77	1 321,240	264,825	351,543	321,978	320,695	339,080	392,970	356,910	895,518	322,260	361,500
		805,836			994,216			1,088,960			1,579,278
	_					-					

372,358 4,468,290 37,236

YTD analysis

AMV	Sales	Rev.Est sale	Variation	Sales	Rev. Est.sales	Var. to date	Last year	Variation	Last year	Variation
Prev. year	Curr. month	Curr. month	%	to date	to date	sales v proj	month	%	to date	%
254,856	361,500	350,000	3.29%	4,468,290	4,050,000	10.33%	269,847	33.96%	3,058,277	46.10%

Total estimated sales 97:

4,050,000

1998
revised Est.sales
Actual sales
Quarterly sales
Monthly average
Annual Total
Annual CYP

January	February	March	April	May	June	July	August	September	October	November	December
375,000	375,000	375,000	400,000	400,000	400,000	425,000	425,000	425,000	450,000	450,000	450,000
302,580	433,560	529,320	405,843	353,808	428,268	459,872					
		1,265,460			1,187,919			459,872			0

416,179 2,913,251 24,277

YTD analysis

ΑN	١٧	Sales	Rev.Est sale	Variation	Sales	Rev. Est.sales	Var. to date	Last year	Variation	Last year	Variation
Pre	ev. year	Curr. month	Curr. month	%	to date	to date	sales v proj	month	%	to date	%
	372,358	459,872	425,000	8.21%	2,913,251	2,750,000	5.94%	339,080	35.62%	2,139,132	36.19%

Total estimated sales 98: 4,950,000